COMMUNITY HEALTH PARTNERS

Patient Information: Annual Update

Please complete all information on both sides of this form. Include only patient's information below.

If you are filling out this form for a minor or someone else (not yourself), write only that person's information

Patient's Legal Name:_____ **Preferred Name:** _____

Other names you have used: _____

Legal guardian (if under age 18):_____

Social Security Number:_____ **Date of Birth**:_____ **Sex Assigned at Birth**: □ Male □ Female
Month/Day/Year

Mailing Address _____
Address or P.O. Box **City** **State** **Zip**

Phone _____ **Email** _____

Community Health Partners receives some federal funding. Therefore, we are required to ask the following questions. All information will be kept strictly confidential. Please complete all the information below.

Marital Status:_____ **Preferred Language:**_____

Primary Care Provider? _____ **Visually impaired?** □ Yes □ No **Hard of Hearing?** □ Yes □ No

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unavailable/Unknown

Race (check all that apply): □ African American □ Asian □ Pacific Islander □ White □ Native Hawaiian □ Unknown □ American Indian/Alaska Native □ Declined

Employment Status: □ Full time □ Part time □ Disabled □ Retired □ Full-Time Student □ Part time Student □ Unemployed

If Employed, Employer: _____ **Military Veteran?** □ Yes □ No □ Active Military

In the past two years, have you: 1. Moved to a new location to do farm or ranch work? □ Yes □ No
2. Done farm or ranch work on a seasonal basis? □ Yes □ No

In the past year have you lived in a shelter, halfway house, in your vehicle or on the street, or temporarily lived with family or friends? □ Yes □ No

Sexual Orientation: □ Lesbian, gay or homosexual □ Straight or heterosexual □ Bisexual □ Other □ Don't Know □ Choose not to disclose □ Unknown

Gender Identity: □ Male □ Female □ Transgender Male: Female-to-Male □ Transgender Female: Male to Female □ Other □ Choose not to disclose □ Non-Binary

Emergency Contact: _____ **Phone Number:** _____

Emergency Contact's Relationship to you: _____

□ I am on CHP sliding scale or I would like to apply for the CHP sliding scale discount today.

Second Page

Who is responsible for today's charges? □ Self (adult 18 or older) □ Other (Is a family member or employer responsible for today's charges?)

Only complete this information for the responsible party if you checked "Other" above:

Name: _____ Relationship to you:_____

Address: _____

Social Security #_____Phone: _____ Date of Birth _____
Month/Day/Year

Employer _____

Do you have insurance that can help pay for today's visit? (Please check all that apply)

□ Private Insurance □ Medicaid □ Medicare □ Healthy Montana Kids
□ Workers' Comp □ Auto Accident Coverage

Policy Holder Name: _____ Policy Holder's Birth Date: _____
Month/Day/Year

Insurance Company:_____ Insurance ID Number: _____

Policy Holder Address: _____

Please provide your insurance card with this form. If you don't have your insurance card with you today, please bring it in as soon as possible or you will receive a bill for the full charge.

This information will be requested one (1) time a year if you are not on a sliding fee discount with us. All information will be kept strictly confidential. Please complete all the information below.
Instructions: Start by picking your family size. Then, pick a **box in that row** that best describes your household income.

What is your annual household income?

Family Size	Income Range	Income Range	Income Range	Income Range
1	❑ $0 to $14,580	❑ $14,581 to $21,870	❑ $21,871 to $29,160	❑ $29,161 and over
2	❑ $0 to $19,720	❑ $19,721 to $29,580	❑ $29,581 to $39,440	❑ $39,441 and over
3	❑ $0 to $24,860	❑ $24,861 to $37,290	❑ $37,291 to $49,720	❑ $49,721 and over
4	❑ $0 to $30,000	❑ $30,001 to $45,000	❑ $45,001 to $60,000	❑ $60,001 and over
5	❑ $0 to $35,140	❑ $35,141 to $52,710	❑ $52,711 to $70,280	❑ $70,281 and over
6	❑ $0 to $40,280	❑ $40,281 to $60,420	❑ $60,421 to $80,560	❑ $80,561 and over
7	❑ $0 to $45,420	❑ $45,421 to $68,130	❑ $68,131 to $90,840	❑ $90,841 and over
8	❑ $0 to $50,560	❑ $50,561 to $75,840	❑ $75,841 to $101,120	❑ $101,121 and over
9+	How many people are in your household? _____ What is the combined annual income for all members of your household $_____?			
❑ I choose **not** to provide my family income information.				

Signature _____ Today's Date _____

For Office Use Only
Slide Status: Active □ Date Expired _____ Patient Declined Slide □ Will Return Ppwk by: _____ Entered by_____ Date____